

organization's combined financial statement include the financial information required in this paragraph (c) with respect to a particular entity.

(d) *Reporting and disclosure under ERISA.* (1) For any employees' health benefits plan that includes an MA organization in its offerings, the MA organization must furnish, upon request, the information the plan needs to fulfill its reporting and disclosure obligations (with respect to the particular MA organization) under the Employee Retirement Income Security Act of 1974 (ERISA).

(2) The MA organization must furnish the information to the employer or the employer's designee, or to the plan administrator, as the term "administrator" is defined in ERISA.

(e) *Loan information.* Each organization must notify CMS of any loans or other special financial arrangements it makes with contractors, subcontractors and related entities.

(f) *Enrollee access to information.* Each MA organization must make the information reported to CMS under § 422.502(f)(1) available to its enrollees upon reasonable request.

(g) *Data validation.* Each Part C sponsor must subject information collected under paragraph (a) of this section to a yearly independent audit to determine their reliability, validity, completeness, and comparability in accordance with specifications developed by CMS.

[63 FR 35099, June 26, 1998, as amended at 75 FR 19812, Apr. 15, 2010]

§ 422.520 Prompt payment by MA organization.

(a) *Contract between CMS and the MA organization.* (1) The contract between CMS and the MA organization must provide that the MA organization will pay 95 percent of the "clean claims" within 30 days of receipt if they are submitted by, or on behalf of, an enrollee of an MA private fee-for-service plan or are claims for services that are not furnished under a written agreement between the organization and the provider.

(2) The MA organization must pay interest on clean claims that are not paid within 30 days in accordance with sections 1816(c)(2)(B) and 1842(c)(2)(B).

(3) All other claims from non-contracted providers must be paid or denied within 60 calendar days from the date of the request.

(b)(1) *Contracts between MA organizations and providers and suppliers.* Contracts or other written agreements between MA organizations and providers must contain a prompt payment provision, the terms of which are developed and agreed to by both the MA organization and the relevant provider.

(2) The MA organization is obligated to pay contracted providers under the terms of the contract between the MA organization and the provider.

(c) *Failure to comply.* If CMS determines, after giving notice and opportunity for hearing, that an MA organization has failed to make payments in accordance with paragraph (a) of this section, CMS may provide—

(1) For direct payment of the sums owed to providers, or MA private fee-for-service plan enrollees; and

(2) For appropriate reduction in the amounts that would otherwise be paid to the organization, to reflect the amounts of the direct payments and the cost of making those payments.

(d) A CMS decision to not conduct a hearing under paragraph (c) of this section does not disturb any potential remedy under State law for 1866(a)(1)(O) of the Act.

[63 FR 35099, June 26, 1998, as amended at 65 FR 40328, June 29, 2000; 70 FR 4738, Jan. 28, 2005]

§ 422.521 Effective date of new significant regulatory requirements.

CMS will not implement, other than at the beginning of a calendar year, requirements under this part that impose a new significant cost or burden on MA organizations or plans, unless a different effective date is required by statute.

[68 FR 50858, Aug. 22, 2003]

§ 422.524 Special rules for RFB societies.

In order to participate as an MA organization, an RFB society—

(a) May not impose any limitation on membership based on any factor related to health status; and

(b) Must offer, in addition to the MA RFB plan, health coverage to individuals who are members of the church or convention or group of churches with which the society is affiliated, but who are not entitled to receive benefits from the Medicare program.

§ 422.527 Agreements with Federally qualified health centers.

The contract between the MA organization and CMS must specify that—

(a) The MA organization must pay a Federally qualified health center (FQHC) a similar amount to what it pays other providers for similar services.

(b) Under such a contract, the FQHC must accept this payment as payment in full, except for allowable cost sharing which it may collect.

(c) Financial incentives, such as risk pool payments or bonuses, and financial withholdings are not considered in determining the payments made by CMS under § 422.316(a).

[70 FR 4738, Jan. 28, 2005]

Subpart L—Effect of Change of Ownership or Leasing of Facilities During Term of Contract

SOURCE: 63 FR 35067, June 26, 1998, unless otherwise noted.

EDITORIAL NOTE: Nomenclature changes to subpart L of part 422 appear at 63 FR 35106, June 26, 1998.

§ 422.550 General provisions.

(a) *What constitutes change of ownership*—(1) *Partnership*. The removal, addition, or substitution of a partner, unless the partners expressly agree otherwise as permitted by applicable State law, constitutes a change of ownership.

(2) *Asset transfer*. Transfer of title and property to another party constitutes change of ownership.

(3) *Corporation*. (i) The merger of the MA organization's corporation into another corporation or the consolidation of the MA organization with one or more other corporations, resulting in a new corporate body, constitutes a change of ownership.

(ii) Transfer of corporate stock or the merger of another corporation into the

MA organization's corporation, with the MA organization surviving, does not ordinarily constitute change of ownership.

(b) *Advance notice requirement*. (1) An MA organization that has a Medicare contract in effect and is considering or negotiating a change in ownership must notify CMS at least 60 days before the anticipated effective date of the change. The MA organization must also provide updated financial information and a discussion of the financial and solvency impact of the change of ownership on the surviving organization.

(2) If the MA organization fails to give CMS the required notice timely, it continues to be liable for capitation payments that CMS makes to it on behalf of Medicare enrollees after the date of change of ownership.

(c) *Novation agreement defined*. A novation agreement is an agreement among the current owner of the MA organization, the prospective new owner, and CMS—

(1) That is embodied in a document executed and signed by all three parties;

(2) That meets the requirements of § 422.552; and

(3) Under which CMS recognizes the new owner as the successor in interest to the current owner's Medicare contract.

(d) *Effect of change of ownership without novation agreement*. Except to the extent provided in paragraph (b)(2) of this section, the effect of a change of ownership without a novation agreement is that—

(1) The existing contract becomes invalid; and

(2) If the new owner wishes to participate in the Medicare program, it must apply for, and enter into, a contract in accordance with subpart K of this part.

(e) *Effect of change of ownership with novation agreement*. If the MA organization submits a novation agreement that meets the requirements of § 422.552, and CMS signs it, the new